



EMG/Consult Requisition

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Referral Question: (please send patient profile, medications and relevant laboratory testing/imaging results)

ARM(S)

- median neuropathy / carpal tunnel syndrome
- ulnar neuropathy
- radial neuropathy
- other focal neuropathy _____
- cervical radiculopathy
- brachial plexopathy

LEG(S)

- polyneuropathy
- peroneal neuropathy
- other focal neuropathy _____
- lumbosacral radiculopathy
- lumbosacral plexopathy

Date _____
Referring Physician _____
Address _____

Phone: _____
Fax: _____

FACE

- trigeminal neuropathy
- Bell's palsy / facial neuropathy

DIFFUSE WEAKNESS

- myopathy (must include CK)
- myasthenia (consider acetylcholine rec antibodies)
- ALS / motor neuron disease
(include CK, MRI C and LS spine)

OTHER _____

Select one of the following options: (EMG and consult includes neurologic consultation, appropriate EMG testing, recommendations for investigation and management, and may include follow-up assessments as appropriate)

EMG and Consult – please outline clinical problem below

EMG only – please specify which muscles, nerve roots and nerves to study

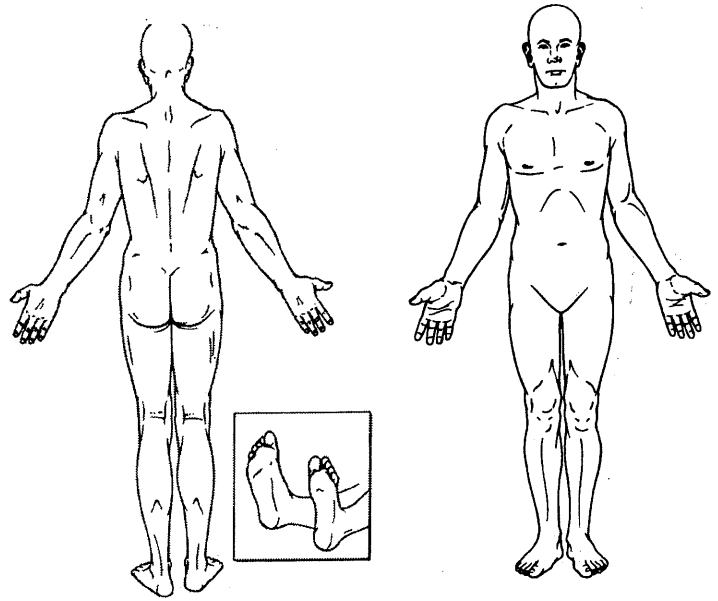
Referring Physician Signature: _____	Family Physician: _____
Billing Number: _____	Appointment Date & Time: _____

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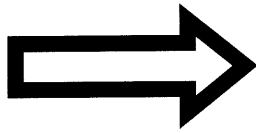
EMG Laboratory History and Exam Form

Date _____
 Name _____
 Phone Number _____
 Birthdate _____
 Age _____

Handedness Right Left
 Occupation _____



Please shade location on diagrams



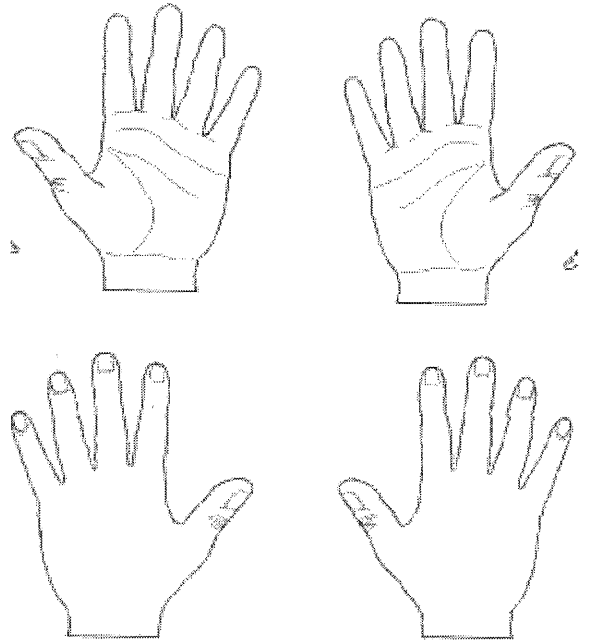
Date of Onset _____

- Symptoms**
- | | |
|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Intermittent | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Improving | <input type="checkbox"/> Worsening |

Symptoms have been stable since _____

Symptoms triggered by:

Symptoms relieved by:



For staff use:



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EMG Laboratory History and Exam Form

Medical History

- | | | | |
|-----------------------------------|--|--------------------------------|--------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Surgical History

- | | | |
|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Medications

- | | | |
|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Allergies

- | | | |
|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
|--------------------------------|--------------------------------|--------------------------------|

For staff use: